patients with coronary heart disease in whom the E.C.G. was abnormal in only 17%.

In summary, there is a specific personality type, displaying particular behaviour traits, who is at high risk for the development of coronary heart disease. When such an individual becomes overstressed by his environment he is liable to develop the symptoms we have termed the 'angry gallop.' We believe that this syndrome represents a pre-infarction state and that decisive steps should be taken to protect the individual without waiting for the infarction which may cause sudden death.—We are, etc.,

P. G. F. NIXON
H. J. N. BETHELL

Charing Cross Hospital,
London W.6

1 Goldstein, S., and Moss, A., American Journal of Cardiology, 1969, 24, 609.

Hospital Advisory Service

Sir,—I enjoy your series “Personal View” and support the concept of independent opinions being freely expressed. However, I would like to correct some of the errors expressed in one of these articles. Perhaps Dr. J. L. Crammer (6 November, p. 550) should have mentioned that he was on leave, or away from the hospital, for some of the time when the team from the Hospital Advisory Service visited.

The team spent two weeks (not three) in the hospital, and his suggestion that their arrival was “semi-secret” and that they had no office or mode of contact would be contrary to this knowledge. Indeed, the day after I wrote to the hospital some weeks before the visit and asked the group secretary to display notices announcing the visit in a prominent place in the hospital. I also wrote independently to the clinical nurse and medical administrator. I asked the group secretary to arrange a meeting when the team arrived, which would include the senior staff members and other heads of departments, to meet with representatives of the management committee. An office was provided for the use of the team and they were in and out of the hospital and this office every day. Also, the group secretary, the hospital administra-
teur, if Dr. Crammer feels that the visit was semi-secret, or that staff in the hospital did not know the team was coming, this may be a reflection on the internal communications of the hospital rather than the Advisory Service.

I note that some of his friends had shown him confidential reports of our visits to other hospitals. I must point out that this kind of information is not frequently used by the hospital administra-
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In my view it is not the intervertebral joint that has become unstable but a frag-

The fact that ligamentous scissors may stop these attacks provides no evidence that the ligaments were the source of pain. The chemically-induced contracture may well further joint stability and abate the tendency to attacks of internal derangement dependent on the presence of a loose fragment of fibro-
cartilage.—I am, etc.,

JAMES CYRIAX
London W.1

1 Hackett, G. S., Joints, Ligament Relaxation, Springfield, Thomas, 1956.
2 Ongley, M. P., AJR, 1945, 58, 436.
5 Cyriax, J., Lancet, 1945, 2, 427.

Brown, Northwood,
Middlesex

1 Howes, R. G., and Isdail, I. C., Rheumatology and Physical Medicine, 1971, 11, 72.

Hospital Advisory Service

Sir,—I was interested and amazed by your leading article (30 October, p. 251) on “The Loose Back”—amazed that the suggestions of Hackett and Isdale are considered to be novel. Most general practitioners are aware that all interested in back disorders know that back-

The “Loose Back”

Sir,—The first edition of Hackett’s book on ligamentous laxity as the cause of backache appeared in 1956. This concept had led Dr. Cyriax to use the term “loose back” and to use a ligamentous laxity as a cause of backache in New Zealand experienced with different agents, and his preferred sclerosant remains that largely employed today.2 These injec-
tions became increasingly popular after Barbor’s favourable report.3 When these in-
jections were tried out by him on 67 cases regarded by myself as entirely incurable 34 cases were relieved and had stayed so for a year later.4 It is not clear to me how ligamentous laxity can of itself cause pain. The greatest degree of lumbar laxity occurs when one disc has become completely eroded. In such a case the patient becomes tilted and has become up to 1 cm long but, too, or symp-
toms necessarily ensue.

In my view it is not the intervertebral joint that has become unstable but a frag-

The fact that ligamentous scissors may stop these attacks provides no evidence that the ligaments were the source of pain. The chemically-induced contracture may well further joint stability and abate the tendency to attacks of internal derangement dependent on the presence of a loose fragment of fibro-
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